



Memorandum

Date OCT 9 2003

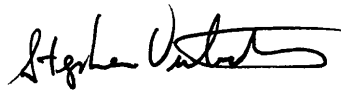
From Regional Inspector General for Audit Services

Subject Audit Report – REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT SHADY GROVE ADVENTIST HOSPITAL, ROCKVILLE, MARYLAND (Report Number A-03-03-00004)

To Sonia A. Madison
Regional Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of the U. S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Outpatient Cardiac Rehabilitation Services at Shady Grove Adventist Hospital, Rockville, Maryland." This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The objectives of our review were to ascertain whether Shady Grove Adventist Hospital's (Shady Grove) policies and procedures complied with Medicare requirements and whether Medicare properly reimbursed Shady Grove for outpatient cardiac rehabilitation services. Should you have any questions or comments concerning the matters commented on in this report, please contact me or have your staff contact Eugene Berti, Audit Manager at 215-861-4474.

To facilitate identification, please refer to Report Number A-03-03-00004 in all correspondence relating to this report.


Stephen Virbitsky

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES

150 S. INDEPENDENCE MALL WEST

SUITE 316

PHILADELPHIA, PENNSYLVANIA 19106-3499

OCT 9 2003

Report Number: A-03-03-00004

Kenneth B. DeStefano
Vice President and General Counsel
Adventist HealthCare
1801 Research Boulevard, Suite 301
Rockville, Maryland 20850

Dear Mr. DeStefano:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Outpatient Cardiac Rehabilitation Services at Shady Grove Adventist Hospital Rockville, Maryland." This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The objectives of our review were to ascertain whether Shady Grove Adventist Hospital's (Shady Grove) policies and procedures complied with Medicare requirements and whether Medicare properly reimbursed Shady Grove for outpatient cardiac rehabilitation services. Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

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To facilitate identification, please refer to Report Number A-03-03-00004 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Sonia Madison
Regional Administrator
Centers for Medicare & Medicaid Services, Region III
Public Ledger Building, Suite 216
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC
REHABILITATION SERVICES AT
SHADY GROVE ADVENTIST HOSPITAL,
ROCKVILLE, MARYLAND**



**OCTOBER 2003
A-03-03-00004**

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & Medicaid Services to determine the level of provider compliance with national Medicare outpatient cardiac rehabilitation policies.

OBJECTIVE

The overall objective of our review was to determine whether Medicare properly reimbursed Shady Grove Adventist Hospital (Shady Grove) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Shady Grove's policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses; and
- Payments to Shady Grove for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during calendar year (CY) 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, Shady Grove contracted with a physician to supervise the services provided by its cardiac rehabilitation program. The physician's responsibilities included approval of cardiac rehabilitation treatment plans and review of patients' medical records. However, our review disclosed that the physician generally was not in the exercise area during regularly scheduled exercise sessions, and he generally did not see the patients.

In addition, from our specific claims review for a sample of 30 beneficiaries with claims for outpatient cardiac rehabilitation services during CY 2001, we determined that Shady Grove received Medicare payments of \$9,127 for:

- Services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (8 beneficiaries);
- Services exceeding 36 sessions (2 beneficiaries);
- Services unrelated to cardiac rehabilitation (1 beneficiary);
- Duplicate services for a single cardiac rehabilitation session (1 beneficiary);
- Claims containing non-covered diagnoses codes (12 beneficiaries);
- A claim containing an incorrect procedure code (1 beneficiary);
- Services for which Shady Grove's medical records did not contain any documentation (4 beneficiaries); and

- Services for which Shady Grove’s medical records did not contain sufficient documentation (9 beneficiaries).

The sample errors and Medicare payments are part of a larger statistical sample and will be included in the multistate projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

We attribute these questionable services to weaknesses in Shady Grove’s internal controls and limited billing system edits. Most notably, Shady Grove did not consistently ensure that beneficiaries had an adequately supported Medicare covered diagnosis supported by the referring physician’s medical records; that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained; and that claims for services were based only on allowable Phase II cardiac services rendered.

Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. We believe that Shady Grove’s fiscal intermediary, Mutual of Omaha (Mutual), should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that Shady Grove:

- Work with Mutual to ensure that Shady Grove’s outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided “incident to” a physician’s professional service;
- Work with Mutual to establish the amount of repayment liability, estimated to be \$9,127, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable;
- Enforce existing policies to ensure that (1) medical record documentation is obtained and maintained to support Medicare outpatient cardiac rehabilitation services and (2) cardiac rehabilitation staff bill only for Phase II cardiac rehabilitation services rendered; and
- Develop billing system edits to ensure only covered diagnoses codes and the appropriate number of sessions are billed.

Shady Grove concurred with our recommendations. Specifically, Shady Grove supports the recommendations and will work with the FI to ensure that they are implemented. We summarized Shady Grove’s response along with our comments after the Recommendations section of the report. The full text of Shady Grove’s response is included as Appendix B to this report.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
Medicare Coverage	1
Cardiac Rehabilitation Programs	2
OBJECTIVES, SCOPE, AND METHODOLOGY	2
Objective	2
Scope	3
Methodology	3
RESULTS OF AUDIT	4
PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION	4
Direct Physician Supervision	4
“Incident To” Physician Services	5
MEDICARE COVERED DIAGNOSES AND DOCUMENTATION	6
Categories of Errors	7
Medicare Covered Diagnoses	7
Billing Procedures	8
Documentation of Services	9
Underlying Causes for Errors	10
Medicare Covered Diagnoses	10
Billing Procedures	10
Documentation of Services	11
RECOMMENDATIONS	11
Shady Grove Response	12
OIG Comments	12
APPENDICES	
STATISTICAL SAMPLE SUMMARY OF ERRORS	A
SHADY GROVE ADVENTIST HOSPITAL COMMENTS	B

INTRODUCTION

BACKGROUND

Medicare Coverage

The Medicare program, established by title XVIII of the Social Security Act (Act), provides health insurance to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS). CMS currently covers Phase II outpatient cardiac rehabilitation programs conducted in specialized, free-standing cardiac rehabilitation clinics and in outpatient hospital departments under the “incident to” benefit (section 1861(s)(2)(A)) of the Act.

Medicare coverage policy for cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Medicare coverage of outpatient cardiac rehabilitation programs is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physicians, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Services provided in connection with the cardiac rehabilitation program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions per week in a single 12-week period. Each cardiac rehabilitation session is considered to be one unit of service.

Cardiac rehabilitation is provided by nonphysician personnel, who are trained in both basic and advanced life support techniques and exercise therapy for coronary disease, under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require a physician to be physically present in the exercise room itself. For outpatient therapeutic services provided in a hospital, the Medicare Intermediary Manual states, “The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.”

In order to be covered under the “incident to” benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of the physician’s professional service in the course of diagnosis or treatment of an illness or injury. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment program.

Cardiac Rehabilitation Programs

Cardiac rehabilitation consists of comprehensive programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Cardiac rehabilitation programs are typically divided into three phases, as follows:

- Phase I. Phase I rehabilitation is initiated in the acute convalescent period following a cardiac event during the hospital phase of treatment. This phase of cardiac rehabilitation is considered part of the hospital stay.
- Phase II. Phase II begins with a physician's prescription (referral) after the acute convalescent period and after it has been determined that the patient's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. This phase requires close monitoring and is directed by a physician who is on-site. Phase II outpatient cardiac rehabilitation is covered by Medicare.
- Phase III. Phase III begins after completion of Phase II and involves a less intensively monitored aerobic exercise program. Phase III level programs are considered maintenance and are not covered by Medicare.

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. However, since 1977 Maryland's hospitals have operated under a waiver from Medicare's reimbursement methodology for hospital services. Under the waiver, Medicare reimburses Maryland hospitals on the basis of rates set by the state's Health Services Cost Review Commission. The FI for Shady Grove Adventist Hospital (Shady Grove) is Mutual of Omaha (Mutual). For CY 2001, Shady Grove billed for outpatient cardiac rehabilitation services to 98 Medicare beneficiaries and received \$104,179 in Medicare reimbursement for these services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the CMS Administrator to determine the level of provider compliance with Medicare coverage requirements for outpatient cardiac rehabilitation services. As such, the overall objective of our review was to determine whether Medicare properly reimbursed Shady Grove for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Shady Grove's policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses; and

- Payments to Shady Grove for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during CY 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

Scope

To accomplish these objectives, we reviewed Shady Grove's policies and procedures and interviewed staff to gain an understanding of Shady Grove's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. Specifically, we reviewed Shady Grove's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation program staffing, maintenance and availability of advanced cardiac life support (ACLS) equipment, and documentation of services provided to beneficiaries and billed to Medicare. In addition, for a statistical sample of beneficiaries for whom Shady Grove billed and received Medicare payment for CY 2001 outpatient cardiac rehabilitation services, we reviewed Shady Grove's cardiac rehabilitation services documentation, hospital medical records, referring physician medical records and referrals, and Medicare reimbursement data.

As part of a multistate statistical sample, we reviewed 30 of 98 Medicare beneficiaries for whom Shady Grove received payment for CY 2001 outpatient cardiac rehabilitation services. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 30 beneficiaries during CY 2001.

We conducted our audit in accordance with generally accepted government auditing standards.

Methodology

We compared Shady Grove's policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and FI local medical review policy and identified any differences. We documented how Shady Grove's staff provided direct physician supervision for cardiac rehabilitation services and verified that Shady Grove's cardiac rehabilitation program personnel were qualified in accordance with Medicare requirements. We also verified the availability of ACLS equipment in the cardiac rehabilitation exercise area.

For each sampled beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to Shady Grove's outpatient cardiac rehabilitation program's documentation. We reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service. We also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's hospital medical record, the referring physician's medical record and referral (for beneficiaries with angina or no readily identifiable Medicare covered diagnosis), and Shady Grove's outpatient cardiac rehabilitation medical record. In addition, we verified that Medicare did not reimburse Shady Grove beyond the maximum number of services allowed.

The medical records have not yet been reviewed by FI staff. In accordance with the intent of CMS's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing Medicare coverage requirements.

We performed our fieldwork at Shady Grove, Gaithersburg, Maryland, and the Philadelphia Regional Office between February and May 2003.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, Shady Grove contracted with a physician to supervise the services provided by its cardiac rehabilitation program staff. The physician's responsibilities included approval of the cardiac rehabilitation treatment plans and review of patients' medical records. However, our review disclosed that the physician was generally not in the exercise area during regularly scheduled exercise sessions, and he generally did not see the patients.

In addition, from our specific claims review for a sample of 30 beneficiaries, with paid claims for outpatient cardiac rehabilitation services during CY 2001, we determined that Shady Grove billed and received Medicare payments of \$9,127 for:

- Services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (8 beneficiaries);
- Services exceeding 36 sessions (2 beneficiaries);
- Services unrelated to cardiac rehabilitation (1 beneficiary);
- Duplicate services for a single cardiac rehabilitation session (1 beneficiary);
- Claims containing non-covered diagnoses codes (12 beneficiaries);
- A claim containing an incorrect procedure code (1 beneficiary);
- Services for which Shady Grove's medical records did not contain any documentation (4 beneficiaries); and
- Services for which Shady Grove's medical records did not contain adequate documentation (9 beneficiaries).

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

Medicare requirements for outpatient cardiac rehabilitation state that direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. The physician supervision requirement is generally assumed to be met when the services are performed on hospital premises.

According to Shady Grove cardiac rehabilitation center personnel, the medical director is a physician under contract to provide direct physician supervision to the cardiac rehabilitation center's exercise staff. The medical director's contract required the physician to serve as the director of the program. However, neither the medical director's contract nor the cardiac

rehabilitation program's policies and procedures specifically required the medical director to be in the exercise area or immediately available during exercise hours.

We observed that the medical director, or a member of his staff, was always on-call during center operation hours. On-call, however, meant that the physicians could be in the cardiac rehabilitation center, across the hall in the cardiac catheterization laboratory, visiting patients in the hospital, or in their offices in the hospital. The cardiac rehabilitation center provided us with the doctors' monthly schedules, but we could not determine where the doctors were while cardiac rehabilitation exercise sessions were being conducted.

On a day-to-day basis, the registered nurses and/or the exercise physiologist staffed and ran the cardiac rehabilitation program. In the event of an emergency, the Shady Grove cardiac rehabilitation center staff would call (1) the hospital's emergency response "code blue" team comprised of therapists, nurses, and the house physician, (2) 911 and request an ACLS unit, and (3) the cardiac rehabilitation center's medical director. The "code blue" team was responsible for responding to any medical emergency that occurred throughout the hospital, including the cardiac rehabilitation exercise area.

During our review, we obtained documentation of two emergency events that occurred in the cardiac rehabilitation center in 2001 and 2003. In the 2001 incident, a patient's heart rate dropped and the staff called a "code blue." Documentation showed that the cardiac rehabilitation's ACLS-trained staff began performing medical treatment within minutes, but the documentation indicated that a physician did not arrive on-site until 13 minutes after the code was initiated. In the 2003 event, a patient suffered ventricular tachycardia, and the cardiac rehabilitation center staff called a "code blue." The cardiac rehabilitation staff started life saving techniques within 3 minutes. The documentation supported that the supervising physician was on-site, however, it did not include a response time for the medical director.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that Shady Grove should work with Mutual to determine whether Shady Grove's practices of having doctors on-call and utilizing an emergency response "code blue" team conforms with Medicare requirements.

"Incident To" Physician Services

Medicare covers Phase II cardiac rehabilitation under the "incident to" benefit. In an outpatient hospital department, the "incident to" benefit does not require that a physician perform a personal professional service on each occasion of service by a nonphysician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient, periodically and sufficiently often, to assess the course of treatment, the patient's progress and, where necessary, to change the treatment program.

At Shady Grove, the medical director approved treatment plans and performed reviews of the patients' records. After a physician referred a patient to Shady Grove's cardiac rehabilitation center, the center's registered nurses and/or exercise physiologist conducted a patient assessment. During the assessment, the cardiac rehabilitation staff reviewed the patient's

medical and social histories, physical condition, and medications and prepared a plan of care flow sheet. After the assessment, the cardiac staff developed the patient's treatment plan that included the exercise prescription. We reviewed the 30 sampled beneficiaries' medical records and determined that the medical director approved all treatment plans, as evidenced by his signature.

Additionally, the cardiac rehabilitation staff performs an ongoing assessment at each exercise session to determine the need for changes in medication and changes in patients' conditions since the last exercise session. The staff communicates progress and problems to the medical director during his rounds. The medical director explained that he receives updates from the cardiac rehabilitation staff daily and he performs medical record reviews weekly. He does not necessarily sign the medical documentation as evidence of his weekly review.

The medical director generally does not personally meet with the patients. As previously discussed, the medical director is apprised of patient status via the daily meetings and record reviews. If a significant issue arises, the medical director said he immediately gets involved. Otherwise, he said he rarely meets the patients personally. He explained that this is a very sensitive issue because he is responsible for the patient's cardiac rehabilitative care, not the patient's overall treatment.

Because Shady Grove's policies required the medical director to review and approve the patients' treatment plans, but did not require the medical director to see the patients, we were not able to determine whether Shady Grove's cardiac rehabilitation program met the requirements for providing "incident to" services. Accordingly, we recommend that Shady Grove coordinate with Mutual to ensure that Shady Grove's cardiac rehabilitation program is operating in accordance with Medicare's requirements for "incident to" services.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage policy considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass surgery, and/or (3) have stable angina pectoris. Medicare only reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. Documentation for these services must be maintained in the patients' medical records. Medicare allows that "services provided in connection with a cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions a week in a single 12 week period."

Our statistical sample of 30 of 98 Shady Grove Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to \$31,942 during CY 2001, disclosed that Medicare claims for 21 beneficiaries contained 38 errors totaling \$9,127. Some claims had more than one type of error. Categories of errors and underlying causes are presented below.

Categories of Errors

Medicare Covered Diagnoses

For eight beneficiaries, Shady Grove billed and received payment for outpatient cardiac rehabilitation services when the diagnoses used to establish the beneficiaries' eligibility for cardiac rehabilitation may not have been supported by notes in the beneficiaries' medical records. As shown in Appendix A, Table 1, we determined that sampled beneficiaries participated in the cardiac rehabilitation program based on the following Medicare covered diagnoses: myocardial infarction (8 beneficiaries), coronary artery bypass graft surgery (11 beneficiaries), myocardial infarction and coronary artery bypass graft surgery (2 beneficiaries). Of the remaining nine beneficiaries: eight beneficiaries participated in the program based on a diagnosis of angina, unspecified and one beneficiary did not participate in the cardiac rehabilitation program.

For the 21 beneficiaries with diagnoses of myocardial infarction and/or coronary artery bypass graft surgery, medical records contained documentation to support the diagnoses. For the eight beneficiaries that participated in the program based on the unspecified angina diagnosis, the beneficiaries' medical records did not contain any indication that the beneficiaries experienced stable angina after a cardiac procedure. As discussed later in the report, one beneficiary did not receive Phase II cardiac rehabilitation services at Shady Grove, therefore, we did not validate whether the patient's diagnosis was covered by Medicare.

Each of the eight beneficiaries who qualified for cardiac rehabilitation based on the unspecified angina diagnosis received treatment at Shady Grove or another local hospital for cardiac related symptoms such as unstable angina or ischemia. Only one beneficiary's hospital medical record contained the specific diagnosis "stable angina." According to hospital records, seven of the eight beneficiaries underwent cardiac procedures such as catheterization, stenting, or angiography. The remaining beneficiary was managed using his personal medication schedule because he was too high risk for intervention. After the hospital visits/stays, the beneficiaries' physicians referred the patients to the Shady Grove cardiac rehabilitation center.

According to Shady Grove's procedures, the Shady Grove cardiac rehabilitation center staff conducts an initial assessment of each beneficiary and prepares a patient information sheet to record intake information including details of the patient's diagnosis. After the assessment, the cardiac rehabilitation center staff requests, as appropriate, the following documentation from the referring physician and/or the hospital: history and physical information; hospital discharge summary; most recent copy of exercise stress test/electrocardiogram (ECG); and operative report.

For the eight beneficiaries, we found that the documentation maintained by Shady Grove did not support whether the patients experienced angina symptoms post-procedure or had another Medicare covered diagnosis within twelve months prior to beginning the cardiac rehabilitation program. Consequently, to validate a stable angina diagnosis or another Medicare covered diagnosis, we obtained and reviewed the hospital medical records as well as the referring physicians' medical records for the eight beneficiaries with unspecified angina. The medical

records obtained covered the dates of the beneficiaries' hospital visit/stay through their completion of Phase II of the cardiac rehabilitation program.

For all eight beneficiaries, our review of the medical records did not reveal any indications that the beneficiaries (1) experienced or continued to experience angina symptoms post-procedure and throughout their completion of Phase II of the cardiac rehabilitation program or (2) had another Medicare covered diagnosis within one year prior to beginning the cardiac rehabilitation program. As a result, Medicare may have inappropriately paid \$8,476 to Shady Grove for the cardiac rehabilitation services provided to these 8 beneficiaries.

Billing Procedures

Services Exceeded 36 Sessions

For 2 sampled beneficiaries, Shady Grove cardiac rehabilitation center billed and received payment for 16 services that exceeded Medicare's 36-session limit. For one beneficiary, Shady Grove billed and received payment for 39 services; and for the other, Shady Grove billed and received payment for 49 services. Contrary to Medicare requirements, Shady Grove did not have any documentation to justify the need for additional services. Shady Grove received \$236 for the excess cardiac rehabilitation services provided to these two beneficiaries.

Services Unrelated to Phase II Cardiac Rehabilitation

For one beneficiary with three services, Shady Grove billed and received payment for Phase II cardiac rehabilitation services, but the actual services rendered were unrelated to Phase II cardiac rehabilitation. The cardiac rehabilitation center at Shady Grove provided other cardiac rehabilitative services in addition to the Phase II cardiac services under review. This sampled beneficiary participated in Shady Grove's other cardiac program, not Phase II. Because this beneficiary's services did not constitute Phase II rehabilitation, Shady Grove should not have billed Medicare for Phase II services. Shady Grove cardiac rehabilitation center improperly received \$146 for the non-Phase II cardiac rehabilitation services provided to this beneficiary.

Duplicate Billing

For one beneficiary, Shady Grove submitted one bill for two units of services when the beneficiary received only one service. Mutual did not determine the claims were duplicate and paid Shady Grove \$49 for these duplicate charges.

Non-Covered Diagnoses Codes

For 12 beneficiaries, Shady Grove's claims included non-covered diagnoses codes. That is, Shady Grove billed Medicare for services with diagnoses codes other than the three diagnoses covered by Medicare. For example, Shady Grove billed Medicare using the diagnosis code for "Abnormal Weight Loss." We found the patient actually suffered an acute myocardial infarction. Because the 12 beneficiaries' medical records supported a Medicare covered

diagnosis or we accounted for the dollars in another finding, there is no monetary effect for this error.

Incorrect Procedure Code

For one beneficiary, Shady Grove improperly billed, and subsequently received payment, for an initial assessment using the procedure code for cardiac rehabilitation services with continuous ECG monitoring. At Shady Grove, the registered nurses or the exercise physiologist conducted the initial assessments that included patient interviews, documentation reviews, and patient orientation to the equipment and monitoring devices. The assessments did not actually include an exercise session with ECG monitoring. Therefore, Shady Grove's use of procedure code 93798 was not appropriate. However, there is no monetary effect for this finding because we accounted for this claim in another finding.

Documentation of Service

No Documentation

Shady Grove billed Medicare for 4 beneficiaries (16 services) when Shady Grove did not document that the beneficiaries received a Phase II cardiac rehabilitation service. Specifically, Shady Grove did not provide any supporting documentation that the four beneficiaries received Phase II cardiac rehabilitation services on the dates billed. For each Phase II exercise session, Shady Grove required all beneficiaries to enter data on the exercise flow sheet and wear ECG monitoring devices. According to Shady Grove cardiac rehabilitation center billing procedures, the cardiac rehabilitation center staff should use the exercise flow sheet to enter claims into their billing system. Shady Grove could not provide the exercise flow sheet, or the ECG data, to support the billed services. Shady Grove received \$220 for these services.

Insufficient Documentation

For nine beneficiaries, Shady Grove billed and received payments for services that were not sufficiently documented on either the patients' exercise flow sheet or ECG printouts. Before each exercise session at Shady Grove, the beneficiary is expected to enter the session date on the exercise flow sheet and attach the ECG monitoring patches to himself/herself. During each session, the cardiac rehabilitation staff entered information about the beneficiary's blood pressure, heart rate, and exercise time on the exercise flow sheet. After each session, the cardiac staff printed the ECG readings and affixed the readings in the patient's file. Although Shady Grove could not provide the missing documentation for these services, we concluded, based on our review of additional documentation, that the patients did receive the services.

The results of our sample will be included in a multistate estimate of Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

Underlying Causes of Errors

Medicare Covered Diagnoses

Shady Grove did not ensure that beneficiaries' stated Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Although Shady Grove cardiac rehabilitation center staff followed the center's policies and requested supporting documentation from the hospital and the referring physician, Shady Grove could not compel either to produce the records. Without such documentation, the Shady Grove could not ensure the patient's participation in the cardiac program was in compliance with Medicare requirements.

Billing Procedures

Services Exceeded 36 Sessions

Neither Shady Grove nor Mutual had billing system edits to determine if services exceeded 36 sessions. Shady Grove cardiac rehabilitation staff were aware of the 36 session limit, but a Shady Grove billing official acknowledged that Shady Grove does not have billing system edits to prohibit Shady Grove from billing for greater than 36 Phase II cardiac rehabilitation sessions. Similarly, a Mutual representative stated that Mutual does not have system edits to deny payment for cardiac rehabilitation services beyond 36 sessions.

Services Unrelated to Phase II Cardiac Rehabilitation

A Shady Grove cardiac rehabilitation center official could not explain why the center billed for one beneficiary's services. This error was likely caused by a keystroke error during the cardiac rehabilitation center's billing process. A Shady Grove official stated that after providing cardiac services, the cardiac rehabilitation staff entered the services into their billing system. The system required the staff to choose from a listing of all of the services provided by the center. The cardiac center's billing system electronically interfaced with the Shady Grove billing system that generated the bill to Medicare.

Duplicate Billing

A Shady Grove billing official could not explain why the service was billed twice, however he agreed to contact Mutual to request an adjustment.

Non-Covered Diagnoses Codes

Shady Grove billed Medicare using non-covered diagnoses codes because different coders processed the claims throughout the exercise program. At Shady Grove, the cardiac rehabilitation center billed claims for services monthly. The claims processed through the hospital's main billing system where one of many medical coders entered a diagnosis code, or codes, based on existing information acquired during the patients' initial admission to the outpatient program. Each coder may enter a different code based on his or her interpretation of

the data. Furthermore, the hospital's billing system did not contain edits that would identify if a cardiac rehabilitation claim included non-covered Medicare diagnoses. Finally, during 2001, Mutual's payment system did not contain system edits that would have precluded payment for services with non-covered Medicare diagnoses.

Incorrect Procedure Code

Shady Grove's use of incorrect procedure codes likely occurred during the conversion process from the cardiac rehabilitation center's billing system to the hospital's billing system. When the Shady Grove cardiac rehabilitation center staff entered the cardiac services, they had to choose from a series of services including assessment, exercise with monitoring, and exercise without monitoring. For this beneficiary, the staff chose the assessment and exercise with monitoring services. The hospital's main billing system then applied the procedure code for a cardiac rehabilitation service with continuous monitoring and the higher rate for an assessment service. However, because the patient did not participate in a monitored exercise session and the physician did not participate in the initial assessment, neither the code nor the higher rate is correct.

Documentation of Services

No Documentation

Contrary to its own policy, Shady Grove entered services into the billing system without having the required documentation such as the exercise flow sheet.

Insufficient Documentation

Shady Grove could not explain why the exercise flow sheet for one service of one beneficiary was not completed. We observed that the beneficiary was new to the Phase II cardiac program and may have failed to follow protocol and complete his exercise chart. The ECG data for this session, however, documented the beneficiary's heart rate and blood pressure at varying intervals while the beneficiary utilized the treadmill, stationery bike, and weights. For the eight beneficiaries with missing ECG strips, Shady Grove could not locate the requested data. A Shady Grove cardiac rehabilitation official stated that the information was likely misfiled in other beneficiaries' medical records.

Our audit conclusions, particularly those regarding Medicare covered diagnoses, were not validated by medical personnel. Therefore, we believe that Mutual should determine the allowability of the cardiac rehabilitation services and the proper recovery action to be taken.

RECOMMENDATIONS

We recommend that Shady Grove:

- Work with Mutual to ensure that Shady Grove's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct

physician supervision and for services provided “incident to” a physician’s professional service;

- Work with Mutual to establish the amount of repayment liability, estimated to be \$9,127, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable;
- Enforce existing policies to ensure that (1) medical record documentation is obtained and maintained to support Medicare outpatient cardiac rehabilitation services and (2) cardiac rehabilitation staff bill only for Phase II cardiac rehabilitation services rendered; and
- Develop billing system edits to ensure only covered diagnoses codes and the appropriate number of sessions are billed.

Shady Grove Response

In a letter dated August 14, 2003, Shady Grove responded to our draft report. Shady Grove stated that it supports the audit recommendations and will work with Mutual to:

- Ensure that the cardiac rehabilitation program continues to operate in accordance with Medicare coverage requirements;
- Ascertain any repayment obligation [for services] to beneficiaries where medical documentation may not have supported Medicare coverage diagnoses;
- Ensure that medical record documentation is appropriately maintained to support Medicare cardiac rehabilitation services; and
- Ensure that only covered diagnosis codes and procedures are billed.

OIG Comments

For the most part, Shady Grove’s corrective actions, when implemented, will address our concerns. Shady Grove indicated that it would work with Mutual to ensure that its cardiac rehabilitation program continues to operate in accordance with Medicare coverage requirements. However, as stated in our report, we were not able to determine whether Shady Grove’s (1) practices of having doctors on-call and utilizing an emergency response “code blue” team conforms with Medicare requirements for direct physician supervision and (2) cardiac rehabilitation program met the requirements for providing “incident to” services. We believe that Shady Grove, working in conjunction with Mutual, needs to determine if its cardiac rehabilitation, as implemented, meets Medicare coverage requirements.

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of our statistically selected sample of 30 Medicare beneficiaries with claims for outpatient cardiac rehabilitation services at Shady Grove during CY 2001. The 30 beneficiaries reviewed were part of a multistate statistical sample. The results of our sample will be included in the multistate estimate of Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment. The total number of errors per diagnosis is greater than the total sample population, as some beneficiaries had more than one type of error.

Table 1. Summary of Errors by Beneficiary Diagnosis and Type of Error

Sampled Beneficiaries with Diagnosis	Diagnosis	Sampled Beneficiaries with Errors	Diagnosis Errors	Billing Errors					Documentation Errors		Total Errors
			Medicare Covered Diagnoses Errors	Services Exceeding 36 Sessions	Services Unrelated to Cardiac Rehabilitation	Duplicate Billings	Non-Covered Diagnoses Codes	Incorrect Procedure Codes	No Documentation	Insufficient Documentation	
8	Myocardial Infarction (MI)	6	0	0	0	0	6	0	0	3	9
11	Coronary Artery Bypass Graft surgery (CABG)	4	0	1	0	0	1	0	3	2	7
2	MI and CABG	2	0	1	0	0	1	0	1	1	4
8	Angina, unspecified	8	8	0	0	1	4	1	0	3	17
1	Did not Participate in Cardiac Program	1	0	0	1	0	0	0	0	0	1
30		21	8	2	1	1	12	1	4	9	38



Washington Adventist Hospital
Shady Grove Adventist Hospital
Hackettstown Community Hospital
Kessler-Adventist Rehabilitation Hospital
Potomac Ridge Behavioral Health
Greater Washington Sleep Disorders Centers
Adventist Senior Living Services
Adventist Home Care Services

August 14, 2003

Stephen Virbitsky
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
150 South Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106 -3499

SUBJECT: Report Number A-03-03-00004

Dear Mr. Virbitsky:

This letter is intended to respond the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' draft report entitled "Review of Outpatient Cardiac Rehabilitation Services at Shady Grove Adventist Hospital, Rockville, Maryland."

Shady Grove Adventist Hospital supports the recommendations made by your office, and will work with our fiscal intermediary to:

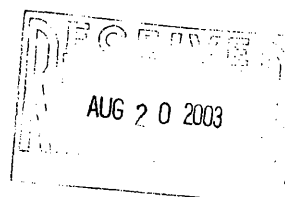
- ensure that our cardiac rehabilitation program continues to operate in accordance with the Medicare coverage requirements,
- ascertain any repayment obligation to beneficiaries where medical documentation may not have supported Medicare coverage diagnoses,
- ensure that medical record documentation is appropriately maintained to support Medicare cardiac rehabilitation services; and
- ensure that only covered diagnosis codes and procedure codes are billed.

Thank you for the opportunity to participate in this audit. Should you have any further questions or concerns, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'K. DeStefano'.

Kenneth B. DeStefano
Vice President & General Counsel



ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed includes:

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